**The Medicalization of the Human Condition**

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As a psychiatrist who has been in practice since World War II,I have seen many profound changes in our profession. These includethe ascendancy and then decline of psychoanalysis as the goldstandard for treating patients, a far-reaching shift in theeconomic basis of practice, and an increasing emphasis on the"bio" aspect of the biopsychosocial paradigm that has been widelyaccepted as the theoretical model for our work ([1](http://psychservices.psychiatryonline.org/cgi/content/full/53/5/627#R5351221)).

However, the transformation I discuss in this article is thesteady and eager efforts of many psychiatrists to remedicalizetheir profession, to extricate it from the conditions that prevailedin the early postwar period, when a medical identification waslooked upon with an attitude close to disdain by the prevailinganalytic community and when brain activities were relativelyignored as an influence on abnormal behavior. The guiding starof the remedicalization movement has been the successive editionsof the *DSM,* which have been responsible for an atheoretical,symptom-based, and unpsychodynamic diagnostic scheme that hascarried the day not only in this country but around the world.

I do not question that remedicalization was, in principle, necessaryand that it has in many ways had a positive and invigoratingeffect on psychiatry and has led to more effective treatments.However, I do contend that the remedicalization pendulum hasswung too far and that some American psychiatrists, in theireagerness to include all varieties and vagaries of human feelingsand behavior in their professional domain, are running the riskof trying to medicalize not only psychiatry but the human conditionitself. To medicalize the human condition is to apply a diagnosticlabel to various unpleasant or undesirable feelings or behaviorsthat are not distinctly abnormal but that fall within a grayarea not readily distinguishable from the range of experiencesthat are often inescapable aspects of the fate of being human.

It needs to be acknowledged that there is an overlap betweenclear clinical syndromes and unwanted feelings and behaviorsthat are so common that to regard them as diseases or even disorderswould make these terms meaningless. It is worth noting that"mental disorder," a term introduced to avoid using the word"disease," has not been satisfactorily defined by the framersof the *DSM,* who state in *DSM-IV* ([2](http://psychservices.psychiatryonline.org/cgi/content/full/53/5/627#R5351222)), "it must be admitted thatno definition adequately specifies precise boundaries for theconcept of mental disorder."

What conditions can be included in the gray area between normalityand pathology? Examples abound. A prime one is the epidemicof social phobia in our country. Are there really 33 millionAmericans whose shyness and timidity are so extreme as to justifythat diagnosis? A recent article in the *New York Times* ([3](http://psychservices.psychiatryonline.org/cgi/content/full/53/5/627#R5351223)) tracesthe path from what was formerly a personality trait, not alwaysconsidered undesirable, through celebrity enlistment and, witha push from SmithKline Beecham, to medicalization of "what is,essentially, not a medical condition."

Depression is another important example. Severe, clear-cut depression,especially if combined with manic phases, is an unequivocaldisorder that conforms satisfactorily to the medical model.However, less severe episodes of depressive affect cannot alwaysbe accurately distinguished from ordinary human unhappinessor "the blues," states of mind that do not justify a diagnosticlabel. In the words of the author of a recent book about theexperience of depression ([4](http://psychservices.psychiatryonline.org/cgi/content/full/53/5/627#R5351224)), "if depression is an illness thataffects as much as 25 percent of the people in the world, canit, in fact, be an illness?"

I believe that the uncertainty about St. John's wort as a treatmentfor depression illustrates my thesis. A recent carefully controlledstudy found negative results for St. John's wort as a treatmentfor major depression, and the investigators suggested that previousstudies with more favorable results had significant design flaws([5](http://psychservices.psychiatryonline.org/cgi/content/full/53/5/627#R5351225)). I further suggest that one component of the faulty designwas that some of the subjects fell within the gray area I havebeen discussing and would have felt better within a reasonableperiod with or without medication.

Are all high-strung "nervous" people the victims of an afflictionlabeled generalized anxiety disorder? And can we reliably distinguishthe rambunctiousness and distractibility of many boys from attention-deficithyperactivity disorder? Among the personality disorders—ageneral category itself of somewhat doubtful validity—thegray area includes the following dichotomies: paranoid personalitydisorder versus a suspicious turn of mind, schizoid personalitydisorder versus a preference for solitude, avoidant personalitydisorder versus a mild to moderate sensitivity to rejection,and narcissistic personality disorder versus a tendency to beself-centered and to show off.

Finally, can we agree with the Surgeon General that one-fifthof the American people are in need of mental health treatments,without having to ask the same question I have quoted aboutdepression? Does such a figure cast a shadow on the validityof the concept of mental illness itself and lend credence tothose like Thomas Szasz ([6](http://psychservices.psychiatryonline.org/cgi/content/full/53/5/627#R5351226)) who claim that "mental illness"exists only as a social construct?

The framers of the *DSM* and many psychiatrists would supportthe claim that conscientious adherence to *DSM* criteria willprotect from the dangers and confusions I have described. Thisclaim has merit—the criteria serve to delineate and definemost psychiatric disorders and to differentiate them from eachother in a way that is useful for diagnosis and treatment.

However, I believe that the application of *DSM* criteria to theborderline areas I have been discussing is limited by two basicweaknesses. The first is that no subjective checklist of a patient'shistory and complaints can infallibly separate clinical syndromesthat qualify as disorders from various kinds of human discomfortof lesser intensity. What is needed and what is still lackingis some kind of biological marker, such as tissue alterationsor a serologic or imaging abnormality, that can distinguish,say, a clinical depression from a state of unhappiness. Suchbiological markers are available in other branches of medicinebut not in psychiatry, except to a very limited degree. It isalso true that most people who have depression, clinical ornot, have other problems and concerns that affect their feelingsand will influence the criteria by which they are diagnosed.

Second, the motivations and experience of the diagnosing psychiatristmust be taken into account in cases in which the clinical pictureis equivocal. An important incentive for making a *DSM* diagnosisis to qualify the patient for insurance reimbursement, whichis otherwise unavailable. Another incentive might be to justifyprescribing a drug rather than taking a primarily psychotherapeuticapproach when a psychiatrist is skilled in the former but notthe latter modality. Other, less obvious but significant motivationsmay play a role.

To summarize my thesis, I believe that in pursuing the HolyGrail of remedicalization, psychiatry has corrected an errorin one direction but has gone too far in the other. The resulthas been not only the excessive emphasis on medical-model diagnosisbut also a related "furor psychopharmacologus" ([7](http://psychservices.psychiatryonline.org/cgi/content/full/53/5/627#R5351227)) that seeksa specific drug for every aberrant feeling or behavior as ifwe were in quest of a society tranquilized by "Soma" as in thedystopia described in Aldous Huxley's *Brave New World* ([8](http://psychservices.psychiatryonline.org/cgi/content/full/53/5/627#R5351228)).

Another consequence has been the downgrading of psychotherapyexcept when it is used in conjunction with drug treatment. Patientswho seek psychotherapy often experience what can be called "problemsof living," which are defined as conditions that produce psychopathologicalsymptoms that are sufficient to negatively influence a person'swell-being and relationships but not to justify a diagnosisof illness or disorder. Such patients are often best treatedwith psychotherapy alone and not with drugs. Under the tyrannyof "medical necessity," an outmoded and no longer effectivegatekeeper, these patients must either pay for treatment outof pocket or be smuggled into insurance coverage by gaming thesystem with an inaccurate diagnosis, subjecting the therapistto moral risk ([9](http://psychservices.psychiatryonline.org/cgi/content/full/53/5/627#R5351229),[10](http://psychservices.psychiatryonline.org/cgi/content/full/53/5/627#R53512210)). This group of patients, sometimes ratherpatronizingly referred to as the "worried well," has constituteda component of my more than 50 years of practice and of thepractices of colleagues, and we have helped many achieve beneficialresults.Rather than continue the charade I have described, the alternativecourse, as I see it, is for psychiatry to recognize and tryto deal with the fact that ours is a profession that, whileit has one foot firmly planted in medicine, is also deeply involvedin other aspects of the human condition. To this extent it transcendsthe medical model. The integrity of the profession of psychiatryas well as that of other helping professions such as psychologyand social work that also now operate uneasily under the constraintsof a sometimes inappropriate illness model depends on the acceptanceof both aspects of this identity.